The English Social Care Workforce: The vexed questions of low wages and stress

Dr Shereen Hussein, BSc, MSc, PhD
Principal Research Fellow
King's College London
United Kingdom

Introduction

The UK has developed its modern welfare states after WWII (Esping-Andersen, 1999); compared to other European countries is relatively more complex and much less universal, particularly when compared to Scandinavian countries. In England, social care is funded through both public and private funds. The state only provides services to those deemed to be unable to meet the cost of care themselves and through means' tested assessment. This is in sharp contrast with health services (National Health Services [NHS]), which is free and universal in coverage to all British and European Economic Area (EEA) nationals. It is noticeable that in England, the gap between health and social care provision is greater for individuals with higher incomes who often have to pay their full accommodation costs for residential care (Roberston, Gregory and Jabbal, 2014). Overall, publically funded social care provision accounts for only 20 to 25 per cent of all older people accessing social care services (Baxter and Glendinning, 2015).

Reducing social care state spending has been a policy adopted by successive UK governments with the rational of coping with government deficits in the aftermath of the financial crisis in 2008. In the two or three decades before the financial crisis, many welfare states in Europe were going through processes that can be described generically as the "marketisation" of functions previously carried out, at least in part, by the state. Marketisation applied first to nationalised industries. The UK was one of the first European countries to adopt this approach to welfare services starting this process during the Thatcher government (1979-1983). Later on, the personalisation agenda (since 2007) came into effect and was regarded as '*a cornerstone of the modernisation of public services'* (Department of Health [DH], 2006), with personal budgets (a key component of personalization) latter became 'mainstream' part of care provision with the Care Act (2014) strengthens this policy through its Statutory Guidance:

> *Everyone whose needs are met by the local authority … **must** receive a personal budget as part of the care and support plan, or support plan (DH, 2014, 152 Emphasis in original).*

Some argue that the personalisation agenda has assisted the progression of the marketization process and shifted some of the state responsibilities to the individuals (Ferguson, 2007). Through the

personalisation agenda individuals judged to be eligible to receive state support were given control of their own publically-funded budgets, through personal budgets including direct payments, or cash for care, with which to purchase for themselves the services they chose to use. Marketisation has thus increased the role of the private sector through various channels, as outsourced providers who compete for local authority funded care packages and as responding to the a larger pool of 'clients' with purchase power (Brennan et al, 2012; Himmelweit, 2014).

This chapter provides detailed analysis of work structure, wages and the role of gender and migrants in the social care sector in England. It is based on empirical studies on the English social care workforce spanning 2010 to 2016. The chapter starts by providing an overview of the organisation of social care in England and the characteristics of its workforce highlighting the significance of gender and migration in the recruitment and retention to the care sector. It then provides detailed analysis of the extent and perceived reasons of poverty pay in the sector. Primary quantitative and qualitative data obtained from frontline care workers, employers and service users are analysed to further understand the reasons behind persistent low wages in the sector. I then provide evidence of unresolved job stress in the care sector utilising Karasek Control-Demand model and explore subsequent moral distress among social care workers (Karesek, 1998a).

Methods

The findings draw on two research projects: analysis of the National Minimum Dataset in Social Care (NMDS-SC) and the Longitudinal Care Work Study (LoCS), both are funded by the English Department of Health. The NMDS-SC is recognised as the main source of workforce information for the LTC sector in England. There is no sampling frame for the data, rather there is an attempt to collect information from all care providers, completion being encouraged by incentives in training funds offered to care providers; it is assumed the sample is random for the most part. The LoCS study adopts a longitudinal design aiming to achieve a locally representative sample of LTC workers in four different parts of England across the statutory, voluntary and private (independent) sectors. Nested samples of frontline staff and managers were drawn from care providers in these areas. The study gained ethical approval from King's College London and research governance agreement from the four participating local councils. The mixed-method design includes a repeated survey for staff (n=1342) and repeated interviews with employers/managers, frontline staff and users and carers (n=300). The current analysis uses the first two waves of LoCS (T1: 2010-11 and T2: 2012-13); a third wave of the survey and interviews are currently (2016) being undertaken.

The LoCS survey collected the standardised scales of Karasek's Job content Questionnaire ('JCQ'). JCQ is a self-completed instrument designed to identify two crucial aspects: job demands - the stressors existing in the work environment - and job decision latitude (control) - the extent to which

employees have the potential to control their tasks and conduct throughout the working day (Karasek et al., 1998a). The control-demand (CD) model postulates that job strain is the result of an interaction between demand and control. The JCQ social support scale combines both co-workers' and supervisory support scales. Such support is theorized to moderate or buffer the impact of job-related stress (Karasek et al., 1998b); in particular, individuals in high stressor jobs will have lower psychological strain in the presence of social support.

The English Social Care Workforce:

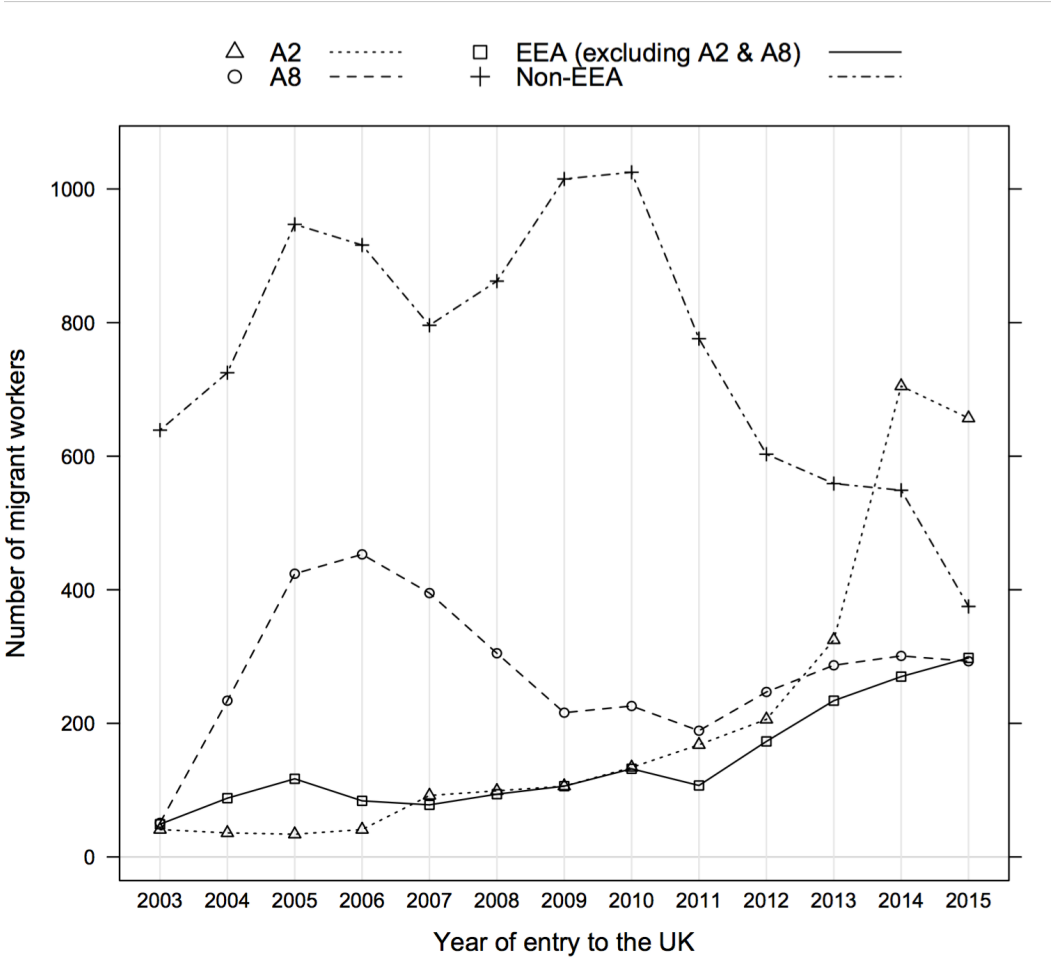
The adult social sector is estimated to employ over two million people at least in the UK (Skills for Care [SfC], 2015), comprising a considerable proportion of the total labour force in England (Office for National Statistics, 2011). 1.4 million of these jobs involve hands-on provision of care ('frontline' jobs), spanning domiciliary (49 per cent), residential (38 per cent) and day and community (13 per cent) service types. These figures include around 180,000 personal assistant jobs in domiciliary care employed by direct payment recipients (service users who receive payments from their local authority to organise their own care).

The sector is characterised by persistent high turnover rates (Hussein et al., 2015) with the independent sector (including private and voluntary) employing three quarters of the workforce (SFC, 2015). Social care provision relies heavily on the human input of the workers, through hands-on support, provision of personal care, practical and emotional support. The workforce is predominantly female – around 83 per cent overall, rising to 85 to 90 per cent of those undertaking direct care-providing jobs. Men account for up to a quarter of the workforce in certain areas, notably day care, support roles and management (Hussein, Ismail and Manthorpe, 2016) and larger proportion of migrant are men when compared to British workers (Hussein and Christensen, 2016).

Historically, the UK has relied extensively on immigration to fill labour shortages; first from Commonwealth states, formerly part of the British Empire (Hussein and Manthorpe, 2005; Redfoot and Houser, 2008). Following early waves of immigration, during the 1960s and 1970s, the UK gradually restricted migration from Commonwealth countries and began to closely link migration policies to economic imperatives such as redressing workforce shortages. However, the UK was one of a minority of EU states that permitted early free labour flows after A8 accession countries (The Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia; Portes and French, 2005). More recently, in 2011, the UK has introduced an 'immigration cap' on non-EU migrants with the help of a points system (Dobson and Salt, 2006) in order to reduce the number of migrants from this group, particularly those seeking to work in low-skilled jobs.

Recent research shows that migrants constitute between 18 and 20 per cent of the English social care workforce (Christensen, Ismail and Hussein, forthcoming), with the prevalence in the capital as high as 50 per cent (Hussein, 2011a). Figure 1 shows analysis based on the NMDS-SC, where employers provided information on the nationality of their workers and year of entry to the UK. The analysis clearly shows that recruitment of migrants to the social care sector reflects recent changes in the UK immigration policies. While traditionally migrants from outside the EU constituted the vast majority of migrant workers in the sector, the profile has changed significantly since 2003. Moreover, the analysis shows that from mid 2013 migrants from A2 countries (Bulgaria and Romania) have exceeded non-EU nationals working in the sector for the first time. However, the implications of the Brexit vote, June 2016, are not yet clear on the migrant social care workforce and the sustainability of care provision in general given the persistent high vacancy and turnover rates and the sector's inability to recruit enough staff (Hussein et al., 2015).

Figure 1 trends of number of migrants working in the social care sector in England by year of entry to the UK and nationality, NMDS-SC February 2016



Low Wages in the English Social Care Sector

The English social sector is characterized by very low pay and difficult working conditions and with fiscal cuts to local government, the social care sector has increasingly become fragmented and casual through outsourcing and other factors (Gardiner & Hussien, 2015; Hussein, 2011). Evidence of low pay in the sector, particularly among direct care workers, is abundant, with the Low Pay Commission highlighting the care sector as one of most vulnerable sectors in terms of its workers being paid on or under National Minimum Wage (NMW) thresholds. The NMW came into effect in the UK during the last nine months of the 20th century (April, 1999), with the care sector arguably one of the main beneficiaries of the introduction of NMW. Nonetheless, social care was, and remains, one of the lowest paying sectors in the UK.

Moreover, the sector has increasingly been suffering from fragmented working-time arrangements, including the wide spread use of zero-hour contracts (Rubery et al., 2015), particularly in the home care sector. Wages are, in the majority, attached to actual face-to-face engagement with service users either in care homes or in their own homes and almost no payment other 'tasks' including being 'on call' and travel time between users for home-based care (Hussein, 2011b; forthcoming; Rubery et al., 2011 and 2015). A recent HM Revenue & Customs (HMRC) campaign targeting social care employers reflects growing concerns around non-compliance and highlights that inappropriate deductions from pay and accommodation offsets are further drivers of National Minimum Wage underpayment as well as lack of payment of between clients' travel time. Nearly half of the care employers investigated were found to be non-compliant (HMRC, 2013).

The vast majority of participants in LoCS interviews indicated that low pay is the norm in the British social care sector, however, the reasons underlying this 'fact' were mixed. Thematic analysis of LoCS in-depth interviews identified poor wages as a direct component of the nature care work. Here there was an implicit, and in some cases explicit, assumption that challenging poor wages or asking for better pay could be regarded as an indication of the unsuitability of an individual to work in the sector. Other determinants observed in the analysis were related to the value the wider society, and consequently the government, places on caring for older people. And the last theme highlighted the impact of current social care policies particularly marketization and outsourcing as well wider fiscal challenges and austerity levels.

The intrinsic nature of frontline care work highlighted earlier is often cited as an explanatory factor of the acceptance of low wages and poor working conditions. These intrinsic justifications were expressed by many frontline social care workers themselves, who repeatedly talked about money not being an important element in their decision to work in care. Some managers expressed views that

those who would like to obtain a decent wage should not consider working in the sector implying that those who are seeking fair wages may lack the right qualities of being a social care worker:

> I think some staff shouldn't be working in this sort of field, because it's just. We don't do it for the money. It's a poorly paid job. You don't get a lot of thanks for what you do. It's a dirty job. Hard work mentally and physically and I don't think we are paid for that sort of level of commitment. We have to be committed. (Manager 1033001; LoCS)

Many participants in the LoCS study highlighted other 'positive' characteristics of the work, such as the ability to work flexibly, as a counter response when asked about their level of pay.

> It [the pay] is so much less than what I used to earn. However, obviously anyone would want more. But the hours work very well for me. And erm, the interaction that I get actually that means that I, one always wants more, but at the same time I enjoy what I am doing. It's okay. (Frontline staff 1099003; LoCS)

However, some participants struggled to convincingly make this argument as payment is attached to strict roles of contact time leaving very little margins for changing circumstances including illness. Yet social care workers seemed to view the problems only in relation to the arrangement of payments rather than the level of wages itself:

> INT: What do you think about your pay and conditions?
> RESP: Well pay, conditions? Oh well I think maybe conditions, 'cause if we don't work, we don't get pay, I suppose a lot of firms like that … Okay, yes I was supposed to be on duty today and I wasn't able to go to work, I was sick for whatever reason, then I wouldn't get pay, or if I was at work and I was taken ill a couple of hours after being at work, then I would only get paid for those two hours. (Frontline staff 1033009; LoCS)

Analysis of LoCS interviews indicated general acceptance that poor wages has always been a feature of social care work and it is not likely to change. For some this was concluded to be mainly associated with the acceptable norms of the society in terms of the value placed on social care work. That is related to the old, disabled and the weak and working in the sector is not seen as part of a wider 'career'. This theme was evident among a large number of managers and service users and reoccurred over time. Some managers explicitly linked low wages to ageism and the value the society places on looking after them:

> Excuse me. I think there is ageism. I think there is under funding. It is real. …. Your biggest cost is staff, so you've got to cut the staffing cost. (Employer, 2099; LoCS)

Most employers/managers spoke about the impact of funding cuts on frontline care workers, while acknowledging the fact that care work pay has always been very low. The amount of pay increases that employers and frontline staff spoke of were very marginal. All wages were governed by the NMW rate but simultaneously working conditions were becoming more difficult particularly in relation to offering sick leave or paying for time spent 'in attendance' between calls or indeed travel time. The very marginal pay increases (5p or 10p) identified by managers were attributed to the austerity measures and progressive outsourcing and privatisation in recent years. However, there was some scepticism about the reality of the inability of the private sector to pay a decent wage and some managers questioned the influence of funding cuts on wages. They argued instead that many private social care providers should afford paying better wages but they are keeping wages as minimum as possible to achieve their main goal of high profit margins.

Stress and Social Care Work

Social care work can be described as an emotionally taxing work, research demonstrates that moral distress is a serious issue for social care workers who deal with some of the most vulnerable groups in the society including older people with dementia and people with severe learning disabilities (Spenceley et al., 2015; Varcoe et al., 2012). Table 3 presents Karasek JCQ scales by social care workers' individual characteristics as derived from the responses to LoCS staff survey. On average, participants scored 71.04 in decision latitude scale (control), 34.96 in psychological job demand (demand), 6.00 in job insecurity and 24.33 in social support scale. To set these figures in context, we compare them to findings from other samples of health and care staff in the UK. The observed levels of job control among social care workers is higher than that observed among English social workers in the field of child protection (68.27; Hussein et al. 2014) and in the field of adult and older people (68.45; Manthorpe et al. 2014). At the same time, the average score of job demand at 34.96 is lower than those observed among child protection (37.78) and adult social workers (36.75) (Hussein et al, 2014; Manthorpe et al., 2014). At the same time, the job insecurity level of 6.00 is slightly higher than those observed among child protection social workers and are very close to those observed among adult social workers.

The analysis indicates that some of these scales vary significantly by some individual and work characteristics. Table 3 shows that women and those who find their personal finance difficult or very difficult to manage, a proxy of poverty pay, display significantly higher levels of job demand (F=4.105, p=0.046 and F=6.557, p<0.011), while workers from black and ethnic minorities have

significantly lower social support. Workers who found their finance difficult to manage also displayed significantly lower job control (F=3.839, p=0.004).

Table 3 Karasek JCQ scales, Decision Latitude, Psychological job demand, job insecurity and social support by social care staff individual characteristics, LOCS

Individual Characteristics		Karasek JCQ Scales			
		Job control	*Job Demand*	*Job Insecurity*	*Social Support*
Gender			*		
	Male				
	Mean (μ)	70.81	34.19	6.17	24.23
	N	202	205	202	201
	Standard deviation (σ)	11.17	6.36	2.10	3.77
	Female				
	μ	71.11	35.16	5.94	24.33
	N	880	884	894	880
	σ	11.29	6.56	2.14	3.75
Nationality					
	British				
	μ	71.03	35.05	5.98	24.35
	N	912	917	924	909
	σ	11.38	6.42	2.12	3.79
	Migrant				
	μ	71.12	34.46	5.93	24.24
	N	179	181	182	181
	σ	10.60	6.98	2.05	3.53
Ethnicity					
	White British				
	μ	71.24	35.01	5.93	24.43
	N	859	863	873	860
	σ	11.30	6.39	2.08	3.75
	Black and minority				
	μ	70.36	34.72	6.07	23.91
	N	204	207	205	203
	σ	11.06	7.11	2.08	3.52
Managing finance		***		**	
	Living very comfortably				
	μ	75.06	34.78	5.34	25.10
	N	68	68	68	67
	σ	12.62	7.35	1.89	4.05
	Doing all right				
	μ	72.61	35.31	5.84	24.53
	N	425	433	437	434
	σ	11.04	6.35	1.85	3.47
	Just about getting by				
	μ	70.11	34.57	6.09	24.14
	N	360	359	362	356
	σ	11.00	36.41	2.32	3.78
	Finding it quite difficult				
	μ	68.60	34.55	6.34	23.97
	N	144	147	145	140
	σ	11.10	6.94	2.26	4.143

Individual Characteristics		Karasek JCQ Scales			
		Job control	*Job Demand*	*Job Insecurity*	*Social Support*
Finding it very difficult					
	μ	68.37	35.61	5.96	24.03
	N	82	79	81	80
	σ	11.19	6.51	2.15	4.08
Total‡	$\boldsymbol{\mu}$	**71.04**	**34.96**	**6.00**	**24.33**
	N	**1149**	**1156**	**1156**	**1143**
	$\boldsymbol{\sigma}$	**11.22**	**6.53**	**2.13**	**3.74**

* Significantly different at $p<0.05$; ** $p<0.005$; *** $p<0.001$; ‡ Sub-groups may not add to total number due to missing values

Table 4 presents the summary statistics job control, demand, insecurity and social support measures by some job characteristics. There are some significant variations by all job characteristics for both job demand and control Mean scores of job control did not significantly change according to any of the job characteristics examined except for unions' membership, with members displaying higher levels of job control ($F=3.390$, $p=0.014$). Both job control and job demand were significantly lower among frontline workers whose job is 'all hands on care' or those who work directly with service users providing intimate and personal care ($F=8.07$ and 37.00, $p<0.001$). Job demand and control were significantly higher among workers who were members of any trade unions ($F=8.26$, $p=0.004$; $F=131.13$, $p<0.001$). Job insecurity seemed to vary the most according to nature of job, with those in administrative post or with little care responsibilities ($F=3.27$, $p=0.021$; and by sector, with those in the public sector having the highest levels of job insecurity ($F=19.04$, $p<0.001$).

It is also interesting to note that those who indicated they belong to trade unions displayed significantly higher levels of job insecurity ($F=23.07$, $p<0.001$). These differences are likely to be related to austerity measures and public cuts, where those who do not provide intensive hands on care or those employed in the public sector feel higher levels of job insecurity. It is also likely that those who belong to trade unions are likely to be employed in local authorities or hold jobs that include elements of administrative and paper work. Interestingly the analysis shows that social support only varies according ethnicity, union membership and sector of work, with those working in voluntary sector reporting the lowest social support levels (which is a combination of co-worker and supervisor support).

Table 4 Karasek JCQ scales, Decision Latitude, Psychological job demand, job insecurity and social support by social care staff job characteristics, LOCS

Job characteristics			Karasek JCQ Scales			
			Job control	*Job demand*	*Job insecurity*	*Social support*
Nature of work			***	***	*	
	All hands on care work					
		μ	68.15	31.68	5.62	24.49
		N	204	209	212	203
		σ	11.38	6.05	2.51	4.08
	Mostly care work					
		μ	70.71	33.72	5.94	24.48
		N	261	263	264	261
		σ	10.07	6.77	2.00	3.52
	Mostly administration with some care work					
		μ	71.22	36.55	6.11	24.20
		N	384	382	378	378
		σ	10.89	6.04	1.96	3.70
	Little or no care work, mainly administration					
		μ	73.09	36.51	6.16	24.25
		N	292	294	294	293
		σ	11.96	6.12	2.06	3.82
Trade Union member			**	***	***	***
	Yes					
		μ	71.98	36.92	6.27	24.01
		N	598	599	598	596
		σ	11.46	6.12	2.09	3.69
	No					
		μ	70.03	32.65	5.66	24.68
		N	496	502	510	497
		σ	10.81	6.21	2.12	3.76
Sector				***	***	**
	Private					
		μ	71.11	32.46	5.54	24.41
		N	368	381	385	371
		σ	11.22	6.29	2.24	3.91
	Public					
		μ	70.98	36.62	6.36	24.49
		N	614	615	608	610
		σ	11.21	6.31	2.09	3.70
	Voluntary					
		μ	71.89	34.59	5.77	23.45
		N	146	151	151	150
		σ	11.05	6.07	1.63	3.37
Total‡	**μ**		**71.04**	**34.96**	**6.00**	**24.33**
	N		**1149**	**1156**	**1156**	**1143**
	σ		**11.22**	**6.53**	**2.13**	**3.74**

* Significantly different at $p<0.05$; ** $p<0.005$; *** $p<0.001$; ‡ Sub-groups may not add to total number due to missing values

Moral distress can be identified as "*the pain or anguish affecting the mind, body, or relationships in response to a situation in which the person is aware of a moral problem, acknowledges moral responsibility, and makes a moral judgement about the correct action"* (Nathaniel, 2004). Analysis of in-depth interviews from LoCS identified a number of situations when "moral distress" could be experienced by social care workers. These include situations where a perceived tension between rights and protection occur; when workers are faced with users' challenging behaviour; when there are discrepancies between the perceived right course of action and workers ability to take such decision; and when time and 'task' constraint their ability to provide the 'right' care. A specific tension occurred when workers' duty to 'protect' collided with what they felt to be tailored and personalised care. These tensions caused dilemmas for care workers that could be manifested in feelings of inability to provide high quality care that in turn could be a factor of distress to the workers.

> There is so much paperwork. If a resident falls or trips over a pair of steps, it's not because oh he's tripped up. They don't do that any more. Look where you are going. You can't say that. You have to write a risk assessment out. … It does,[she points to her heart] that's exactly how it makes you feel. They can't go out in the snow, because they might fall over and hurt themselves. The joy that I had when I was a kid of running in the snow and rolling in the snow and that sort of thing is lost for them.
>
> (Residential care worker, 2105008; LoCS)

Challenging behaviour and use of restraints can also be a cause of moral distress to many social care workers. A particular stressor could be viewed in relation to how challenging behaviour, communication and workers' perception of best practice interact and influence workers' decisions to job quitting, for example:

> I've worked in mental institutes and there are high risks and it used to be called, danger money, because you could expect to either spend your whole day restraining somebody or going through this intensive training programme that teaches you how to be abusive to save your own life having worked with learning disabilities and autism, I disregard challenging behaviour completely. I think it's a form of communication. I think when we experience behaviours from individuals it's because we haven't communicated appropriately.
>
> (Day centre worker, 2277005; LoCS)

The fact that social care workers provide care to the most vulnerable people, some of whom may lack capacity or suffer from extreme memory problems can pose a number of challenges and impact on

workers' stress. It is plausible that social care workers could be accused of abusive behaviour if it proved difficult to establish the exact circumstances surrounding an incidence where service users are hurt for example. Frontline care staff provided several examples where similar situations caused them unnecessary stress, where they either needed to defend themselves or wanted to protect the people they cared for. This residential care worker explains one of these situations:

> We took Paul to the doctors and again because of the autism in that communication obstacles, he couldn't translate the actual problem to the doctor very well and Paul had—with [specific] Syndrome they bruise easily. They can just accidentally walk into a table and they get a massive bruise or something like that. The doctor decided making an investigative questions and enquiries about abuse. Paul only went there for like a cold or something. It's a whole thing that doctors and nurses just assume they know better.
>
> (Residential care worker, 2105012; LoCS)

Most participants identified training and support from supervisors and co-workers to be important in their ability to deal with these situations. However, many also talked about talking to partners and family members about work stressors, which indicate a certain degree of stress spill over to family life.

Conclusion

The British social care system is less universal and more complex than many other European countries, particularly social-democratic welfare states such as Scandinavian countries. The UK was one of the first European countries to marketise care through progressive policies of privatisation, and outsourcing since the Thatcher era with more recent developments of the personalisation agenda. Through these processes care has been transferred into a commodity that is governed by market forces with large share of for-profit organisation. These dynamics create increasing pressures to maximise profit in the main through reducing workforce cost, which accounts for nearly 80 per cent of total care provision cost. Resulting on increasingly low wages, precarious working arrangements and fewer job security measures. Similar to many other countries, the UK social care sector relies on women and migrants who are more likely to accept 'bad jobs' (Kalleberg, 2011). That is low paid, has weak contractual protection with little job security and requires low level of qualifications.

While women constitute the vast majority of this workforce, men remains significantly over represented in managerial and supervisory roles, which have better wages and higher job conditions (Hussein and Manthorpe, 2014), however, not all men enjoy these advantages where race and nationality interact with gender (Hussein et al, 2016). Migrants continued to form a significant part of

the British social care sector, however, since 2003 there has been considerable changes in the profile of these migrants, particularly in relation to source country. The findings based on analysis of the NMDS-SC that while 10 years ago migrants from outside the EU (mainly nurses from the Philippines) constituted the vase majority of migrant social care workers in the UK, by 2014 the major group of migrants are from A2 countries (Bulgaria and Romania). The UK immigration policies are currently very fluid with the most recent vote of British citizens to leave the EU. The implications on social care provision and markets of the Brexit remain to be seen but are likely to be significant given the continuous reliance of the English social care sector on migrants.

The evidence presented here indicates that the English low-skilled, low-status, social care work carries considerable wage penalties for a considerable part of its highly vulnerable workforce. Several authors explain low wages in social care by the intrinsic nature of care work itself and those who ascribe to this work (Duffy et al., 2013). It is argued that the reward gained from the very inherent nature of working with vulnerable individuals in need of care can increase frontline workers' job satisfaction and feelings of self-worth to a certain degree to compensate the bad qualities of the job including very low wages (Morgan et al., 2013; Rakovski and Price-Glynn, 2010). Some argue that the acceptance of poor working conditions can relate to a concept of self-sacrifice adopted by some workers as a way of affirming their own identity at work, where they are seen, by others and themselves, as placing their values ahead of their own needs (Baines and Cunningham, 2011). The analysis presented here, confirms these arguments to a certain extent and thus poses several questions on how to enable the sector to re-evaluate the worth of its work taking into account the in-direct cost of poverty pay, stress and potential health outcomes.

Additionally, the value a society places on the act of caring for older people and those who are 'weak', such as people with disabilities and mental health problems, can also be considered as an explanatory factor of consistently low wages in the social sector, where ageism and discrimination not only affect those individuals but those working with them (Stone and Harahan, 2010). The analysis shows that this is a view shared by many managers and service users who participated in the LoCS study. Moreover, marketization of care presents a situation where care providers operate within a tight public funding structure, leaving private companies to enhance their profits through higher fees for self-funding care users and maintaining low wages and increasing workers' productivity, through shorter visits to perform more tasks or increase the ratio of care recipients per workers (Folbre, 2012).

Persistent low wages and increasingly difficult working conditions carry a heavy penalty for social care workers, particularly those who could be considered as vulnerable workers. Prime among this group women and migrants who may lack other employment options or who have other responsibilities and constraints that prevent them from seeking alternative work. Previous research

shows that such job strain is associated with several adverse health outcomes, most notably cardiovascular disease (Hallqvist et al., 1998; Landsbergis & Theorell, 1999). Thematic analysis of in-depth interviews shows that moral distress among frontline workers can occur in a number of situations, particularly when there is lack of job authority to ensure the perceived appropriate actions as been undertaken. Training and support from co-workers and supervisor was identified as important in reducing the effect of stress. However, the majority of participants indicated that lack of time and increased workload impact negatively on their ability to manage work related stress.

With escalating demands on the formal social care sector, it is crucial to implement both policy and practice measures to reduce poverty-pay, job demand and insecurity among social care workers. These need to be viewed as preventative strategies to maintain the well-being of workers as well as the quality of care to the most vulnerable in society.

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